

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

10083

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10089

Reg. Dist. No. 257

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Queen Anne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Queen Anne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>W. Houghby</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>William Alexander Butler</u>		<u>Oct. 7 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 24 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE last birthday <u>75 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Alexander Butler</u>		14. MOTHER'S MAIDEN NAME <u>S. Katherine Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Bertha Butler - Queen Anne, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>3 yrs.</u>
Antecedent cause (b) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>3 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Sept. 10, 1955</u> , to <u>Sept. 10, 1955</u> , that I last saw the deceased alive on <u>Sept. 30, 1955</u> , and that death occurred at <u>10:30</u> m., from the causes and on the date stated above.		
SIGNATURE <u>William J. Foy MD.</u>		DATE SIGNED <u>10/7/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Oct. 10, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>
LOCATION (City, town, or county) <u>Queen Anne, Md.</u>	LOCATION (City, town, or county) <u>Queen Anne, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>10/8/55</u>	REGISTRAR'S SIGNATURE <u>N. S. Norris</u> <u>Elcie Armstrong</u>	24. FUNERAL DIRECTOR <u>W. H. H. H.</u> ADDRESS <u>Queen Anne, Md.</u>

BUREAU V. S.

OCT 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10090
10084 CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Queen Anne's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Queen Anne's</i>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<i>X</i> <i>Cutherville</i>				<i>Cutherville</i> <i>X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>LIZZIE COKER</i>				<i>Oct 3 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>7</i>	<i>Caucasian</i>	<i>Widowed</i>	<i>May 21 - 1878</i>	<i>77</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Housework</i>				<i>Domestic</i>		<i>Queen Anne's Co. Md</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Oliver Hard</i>				<i>Alphina Hutchins</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:	
<i>Yes</i> <i>WW</i>				<i>None</i>		<i>Josephine Coker Cutherville Md</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1998 IMMEDIATE CAUSE (A) <i>Cancer of stomach & bladder</i>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1 - 1955</i> , to <i>Oct 3 - 1955</i> , that I last saw the deceased alive on <i>Oct 3 - 1955</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>W. Henry Fisher</i>				ADDRESS <i>Cutherville Md</i>		DATE SIGNED <i>10/5-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Oct 5 - 1955</i>		<i>Christfield</i>		<i>Cutherville Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>10-5-1955</i>		<i>Glenn Armstrong</i>		<i>Barton Bros. Cutherville Md</i>			

BUREAU V. S.

OCT 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10085

CERTIFICATE OF DEATH

10091
Reg. Dist. No. 251

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Church Hill</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Church Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>X</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>WILLIAM A. COURSEY</u>				<u>Oct. 5 1955</u>			
5. SEX: <u>m.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED: <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 21-1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter Building</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Samuel C. Coursey</u>				14. MOTHER'S MAIDEN NAME: <u>Randa Edenfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-019-455</u>		17. INFORMANT'S ADDRESS: <u>Frederick Coursey Church Hill Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 5</u> , 19 <u>55</u> , to <u>Oct 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>55</u> , and that death occurred at <u>6:50</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>W. Henry Fisher</u>		ADDRESS <u>M. D. Centerville Md</u>		DATE SIGNED <u>10/6-55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 7</u>		<u>Sudlersville</u>		<u>Shedlersville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-7</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>	

BUREAU V. S.

OCT 10 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10086

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10092

Reg. Dist.

No. 252

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Centerville</u>		<u>all her life</u>		TOWN <u>Centerville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				1			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Dorothy Emory Phillips</u> (Middle) <u>Earle</u> (Last)				(Month) <u>Oct</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>May 19-1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Home near Centerville md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Wm C Emory</u>				14. MOTHER'S MAIDEN NAME: <u>Cora Frances Maffet</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>220-34-9393</u>		17. INFORMANT & ADDRESS: <u>Mrs Dorothy Massey - Massey md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>Found dead in bed</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE SIGNED					
<u>W. Henry Fisher</u>		<u>11/3-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Nov. 4-1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Westfield Cemetery</u>		LOCATION (City, town, or county) (State): <u>Centerville, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11-4-55</u>		<u>Elise Armstrong</u>		<u>Barton Bros. Centerville, Maryland</u>			

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NOV 7 1933
BUREAU V. S.

10087

10093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 253

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Queen Anne</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Stevensville</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>near Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Wm</u>	(Middle)	(Last) <u>Green</u>	(Month) <u>Oct</u> (Day) <u>27</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>ch</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>1887</u>
9. AGE, last birthday: <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>near Stevensville md</u>	
11. BIRTHPLACE (State or foreign country): <u>near Stevensville md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>? Green</u>		14. MOTHER'S MAIDEN NAME: <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>35 Titmus Rd. Glen Cove D.C.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>420.1 Immediate cause (a) <u>Coronary Occlusion</u></p> <p>Antecedent cause(s) (b) <u>This man has complained of heart trouble</u></p> <p>Diseases or conditions, if any, giving rise to the above cause (c) <u>for last 10 yrs</u></p> <p>stating underlying cause last</p>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Fisher - Centerville md</u>		DATE SIGNED <u>10/29-55</u>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
M. D. ASSISTANT MEDICAL EXAM.		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>	DATE THEREOF <u>Oct 30-55</u>	NAME OF CEMETERY OR CREMATORY <u>AME Church Cemetery</u>
LOCATION (City, town, or county) (State) <u>near Stevensville Maryland</u>	24. FUNERAL DIRECTOR <u>Barton Bero</u>	ADDRESS <u>Centerville Maryland</u>
DATE REC'D BY LOCAL REG. <u>Oct 30-55</u>	REGISTRAR'S SIGNATURE <u>Elizabeth H. Hester</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 3 1955

RECEIVED

RECEIVED (NOV 3 1955) THE BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

10098

2411 N. Charles Street, Baltimore

10094

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> <u>Robertson</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q. A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chester</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Em. Raphael</u> (First) <u>Emily</u> (Middle) <u>Hazelton</u> (Last)		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 19, 1891</u>
9. AGE last birthday <u>64</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jerry Hazelton</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Eliza Derry - Chester, Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>48 hrs.</u>
Antecedent cause(s) (b) <u>Angina Pectoris</u>		<u>Sev. Yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1953, to Oct, 1955, that I last saw the deceased alive on Oct. 3, 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>10-7-55</u>	<u>Union Cem</u>	<u>Chester</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>10-5-55</u>	<u>J. B. Johnson</u>	<u>J. B. Johnson</u>	<u>Annapolis</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

10089

2411 N. Charles Street, Baltimore

10095

CERTIFICATE OF DEATH

Reg. Dist. No. 53

Form 2, Film 188 10-27-55 et

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Ind</u> COUNTY <u>8. a</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) *****	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary</u> <u>Thomas</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct</u> <u>17</u> <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED, WIDOWED <input checked="" type="checkbox"/> DIVORCED.	8. DATE OF BIRTH <u>Oct 13-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Julius</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis + hemiplegia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-sclerotic, hypertensive Cardio-vascular disease

(c) mitral regurgitation with decompensation

INTERVAL BETWEEN ONSET AND DEATH

Oct. 5, 1955

3 years

6 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 10th, 1955, to Oct 17, 1955, that I last saw the deceased alive on Oct. 17, 1955, and that death occurred at 2:20 p. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Theodor Sattelmaier M.D. Stevensville Oct. 18, 1955

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>Oct 19-55</u>	<u>Stevensville</u>	<u>Stevensville</u>	<u>Ind</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>#19, 55</u>	<u>Edgar L. Lane</u>	<u>Edgar L. Lane</u>	<u>Chas. Hill</u>	

51

10090

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Queen Anne</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millington</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>HARRY</u>	(Middle)	(Last) <u>WALLACE</u>	
(Type or Print)		OF DEATH <u>Oct. 12 1953</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 13, 1881</u>
		9. AGE last birthday <u>74</u> yrs.	10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>	11. BIRTHPLACE (State or foreign country): <u>Del.</u>
		12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	

13. FATHER'S NAME: <u>John Wallace</u>		14. MOTHER'S MAIDEN NAME: <u>Hermietta Sylvestre</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Mrs. Lula Wallace-Millington Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>334X</u>		<u>3 days</u>
ANTECEDENT CAUSE (S)		
DUE TO (A) <u>apoplexy</u>		
DUE TO (B) <u>Arrhythmia fibrillation</u>		<u>3 years</u>
DUE TO (C) <u>Generalized Atherosclerosis</u>		<u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>none</u>	19B. MAJOR FINDINGS OF OPERATION: <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>none</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR? <u>none</u>

22. I hereby certify that I attended the deceased from Feb 8, 1953, to Oct 12, 1953, that I last saw the deceased alive on Oct 11, 1953, and that death occurred at 6:20 AM, from the causes and on the date stated above.

SIGNATURE J. Hamilton ADDRESS Millington DATE SIGNED Oct 12/53

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct. 16, 1953</u>	NAME OF CEMETERY OR CREMATORY <u>Millington Cem.</u>	LOCATION (City, town, or county) (State) <u>Millington Kent Co. Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 12</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>	24. FUNERAL DIRECTOR <u>Edward Fellows</u>	ADDRESS <u>Millington Md.</u>

MARGIN RESERVED FOR BINDING

6 X-4470110



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10097

10091

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Green Anne</u>	MARYLAND	STATE <u>Ind.</u>	COUNTY <u>g.a.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Centerville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>WESLEY WASHINGTON</u>		<u>Oct. 26 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Jan. 7 - 1892</u>
9. AGE last birthday: <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>James Washington</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Kohn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. (If Yes, give war or dates service))		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <u>Mrs. Wes. Washington - Centerville Ind.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE		(A) <u>Chronic Interstitial Nephritis</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>with Heart Complication</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 10</u> , 19 <u>55</u> , to <u>Oct 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-25</u> , 19 <u>55</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
SIGNATURE: <u>W. Osney Fisher</u>		ADDRESS: <u>Centerville Ind.</u> DATE SIGNED: <u>10/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>Oct 29</u>	
NAME OF CEMETERY OR CREMATORY: <u>Chesterfield</u>		LOCATION (City, town, or county) (State): <u>Centerville Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>10-28</u>		REGISTRAR'S SIGNATURE: <u>Edgar L. Lane</u>	
24. FUNERAL DIRECTOR: <u>Edgar L. Lane</u>		ADDRESS: <u>Church Hill Ind.</u>	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

BUREAU V. N.

NOV 2 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10098

Reg. Dist. No. 252

10092

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Centreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS <u>Starr</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Wilkins</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 6, 1982</u>
9. AGE last birthday <u>72</u> yrs.		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>4</u> (Year) <u>1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Berry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Emma Stanford - Centreville Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>260X</u>		(a) <u>Arteriosclerotic Cardio-Vascular Disease</u>		<u>Yrs</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Diabetes Mellitis</u>		<u>20 yrs. +</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) <u>—</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept., 1953, to Sept., 1955, that I last saw the deceased alive on Sept. 26, 1955, and that death occurred at 11:58 m., from the causes and on the date stated above.

SIGNATURE Irvin D. Hoyt MD (Degree or title) ADDRESS Queenstown, Md. DATE SIGNED 10/5/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>10/9/55</u>	<u>New Town Cem.</u>	<u>Cordova</u>	<u>md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>10-6-55</u>	<u>Elaine Armstrong</u>	<u>James B. Dornier, Easton Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S.

OCT 18 1955

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